D.E.T.E. R.

A Plan to Dramatically Improve Vermont's
Drug Education, Treatment, Enforcement and Rehabilitation Programs

Executive Summary

Introduction

This proposal is a two-pronged effort to address one of societies biggest problems. It focuses on prevention by addressing substance abuse problems facing our youth, and provides more emphasis on treatment for those who are tragically afflicted with this social ill. Highest priority is placed on those efforts that have maximum and immediate effects on the core problems.

"We must do more to protect our children from the life-destroying effects of these drugs. Some of it is tough love, and some of it is just plain love. We will address addiction with a compassionate program of treatment and rehabilitation. And we will educate kids about the dangers of drug abuse so they will have the strength and courage to reject them."

Governor James Douglas
Inaugural address
January 9, 2003

Heroin is inflicting damage on families throughout Vermont in increasing numbers. The expanding use of heroin has stretched the state's resources beyond existing capacities.

Though heroin is more visible, it is not our only problem. Alcohol problems affect many, many more Vermonters.

For too long we have chased the problems of substance abuse . We must reverse the trend of spending money after the damage is done, and make prevention our strategy of first choice.

Therefore, our focus is to provide a comprehensive, sustainable strategy that will address today's problem and reduce tomorrow's risk. Prevention and Education can change norms. Treatment and Rehabilitation can help those who are sick.

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Program Components

⇒ **Education and Prevention**

- **Student Assistance Programs** - Embark on a four-year effort to assure that every middle school and high school has a drug counselor.

- **After School Programs** - increase after school programs and job opportunities to promote positive youth development.

⇒ **Treatment and Rehabilitation**

- **Increase Clinical Treatment Capacity** - Strategically deploy 5 outpatient treatment counselors and 5 case managers throughout the state to provide treatment and aftercare, supporting drug court referrals and patient reintegration into communities, by serving over 600 clients.

- **Opiate Treatment** - Open a second opiate treatment center to help reduce transportation costs and increase capacity in this area of critical need. Over 70 patients on methadone maintenance are traveling to out-of-state programs at significant cost to the state. These patients cannot be bused from St. Johnsbury to Burlington daily. (The agreement with Fletcher Allen will not allow busing groups who while waiting could disturb people receiving other medical care.)

- **Offender Re-entry Program** – Federal funds will allow us to target recovering offenders who need ongoing support beyond their intensive substance abuse treatment. We will provide this support by working with existing community groups who are committed to strengthening their own recovery through assistance to others.

D.E.T.E.R.
Program Narrative

Education and Prevention:

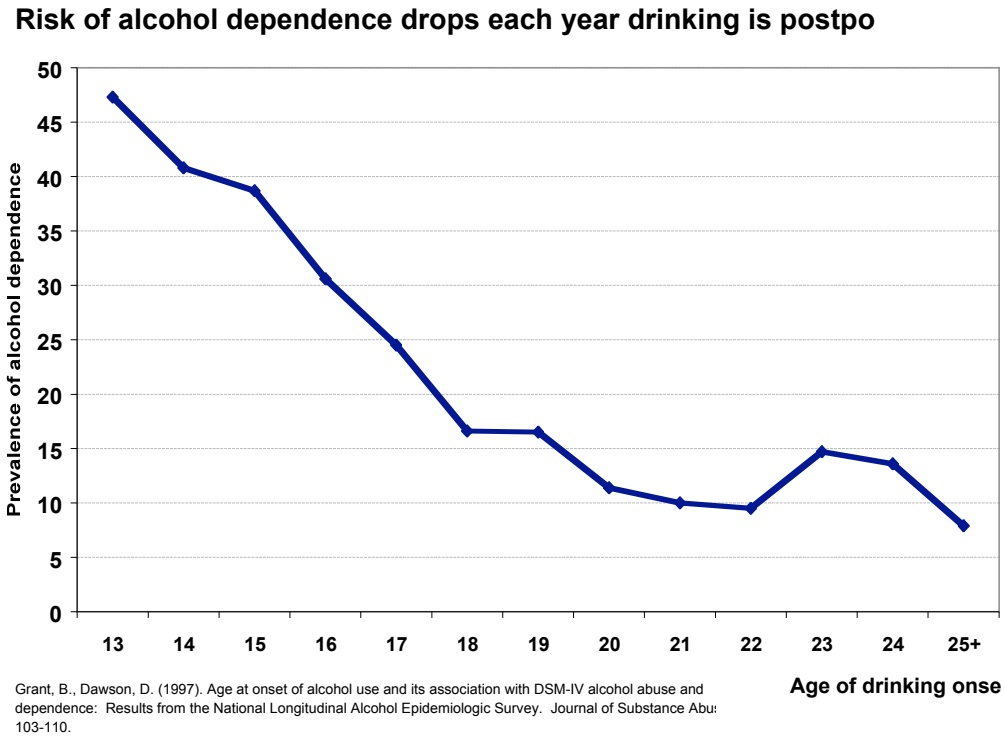
Student Assistance Program

1. Why are Student Assistance Professionals necessary?
SAP's are important for many reasons, but one of the most critical is their role, in the school, to prevent or intervene early when problems occur. Early use shows a striking and clear relationship with risk of later alcohol and drug dependence. SAP's are in a position to prevent early use and to intervene with students who are using.

Early Alcohol and Drug Use

> "***The use of alcohol and tobacco does not necessarily cause young people to use. But there is strong evidence that using these substances sets up patterns of behavior that may make it easier to take the next step and use other drugs.***"
> -American Association of Pediatrics

The impact of starting early…Young people who drink before the age of 13 are almost five times as likely to develop a future diagnosis of alcohol dependence.



Grant, B., Dawson, D. (1997). Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey. Journal of Substance Abu 103-110.

2. What do Student Assistance Professionals (SAPs) do?
SAPs provide services to prevent, screen, identify, intervene, and when necessary, refer students to treatment services. SAP's also provide follow-up; aftercare and recovery support to students after treatment is completed. Because SAPs are continually interacting with students in the school, they can identify students having problems through direct observation. Students may also be referred to SAP's by teachers, parents, peers, or may seek help themselves.

SAPs also:

- meet with concerned families
- give educational presentations
- work with community resources to identify and develop services for students
- train school staff to deal with troubled students
- increase awareness of alcohol and drug use problems in the community
- allow teachers to concentrate on education instead of having to deal with substance use
- run educational support groups
- SAP's complement existing programs such as school-based health clinics, classroom alcohol and drug abuse prevention education, peer leadership programs, and local treatment professionals and agencies.

3. What kinds of problems do they deal with?
They frequently encounter these issues:

- alcohol and drug abuse
- substance abuse of friends/family
- family conflicts
- school behavior
- grades
- mental health issues (depression, stress, anger management, body image, etc.)
- relationships with friends/peers.

4. How effective are they?
The Association of Student Assistance Professionals of Vermont ** cite studies in other states that have shown that the presence of an SAP in schools has:

- reduced substance use (Washington), specifically in alcohol and marijuana use (New York and Wisconsin)
- increased school attendance (New York, Wisconsin, and California)
- decreased drop-outs (California and Pennsylvania)
- decreased disciplinary actions (Wisconsin and Pennsylvania)
- decreased vandalism (Wisconsin)
- improved grades and staff morale (Wisconsin)

The Association of Student Assistance Professionals of Vermont developed a report in 1996, in the *Vermont Student Assistance Programs: Bridging the Gap Between Prevention and Treatment, 1996. Waterbury, VT.*

This report of student assistance programs compared schools with a SAP counselor to those without. School personnel reported that having a SAP was associated with:

- 13 times fewer physical assaults
- seven times fewer threats to staff by students
- half the physical threats to students by other students
- half as many violent incidences in schools
- four times more student self-referrals for drug use or distress.

More recent information from SAP's, as reported by Association of Student Assistance Professionals of Vermont, for FY01, showed that many students who were seen for follow-up by SAP's showed decreases in absences, detentions and/ or suspensions.
** Association of Student Assistance Professionals of Vermont
http://home.adelphia.net/~asapvt/sapwork.htm

Implementation Plan

1. A unified and consistent granting process for SAP's has been developed and was implemented for FY03 grants that will form the basis of implementing grants for new SAP's. Discussions took place that involved staff from the Department of Education, the Department of Health, Division of Alcohol and Drug Abuse Programs, and the Association of Student Assistance Professionals. As a result of these discussions, sources of funding were combined, criteria for awards and standard rates for these services were developed and applied.

2. This same process will be used for all SAP funding for FY04. Review of grant applications will include staff from the Department of Health, the Department of Education, and the Association of Student Assistance Professionals. Under DETER, we will provide funding for an additional 20 schools for FY04. The long term goal is to ensure that all schools in the state will have a Student Assistance Professional in the school at least 2 days a week within 3 years.

3. For FY04 funding of SAP's we expect two phases:

1. General process: In February we will send out an RFP to all schools and use a review process similar to FY03 to make decisions on awards.
2. New positions: The timeline and the dissemination of the RFP will be modified slightly. Schools that do not receive funding as a result of the spring process will be sent a letter in early July asking them to apply for the additional funding.

4. The grant process will be competitive, will focus on schools with middle and high school grades and take into consideration the need (Vermont Youth Risk Behavior Survey indicators) and enrollment in each school. Award decisions are expected to be final prior to the beginning of the school year.

After-School Programs

Why are After-School Programs important?
Research shows that students who effectively use out-of-school time to complete homework, participate in the arts and athletics, and work or volunteer 10 to 12 hours weekly receive better grades and engage less often in risky behaviors or unhealthy relationships.

How are After-School Programs financed?
To promote greater participation in high-quality, out-of-school programs, the No Child Left Behind Act incorporated the 21st Century Community Learning Centers (21stCCLC) program, Title IV-B. Under the program, schools and community-based organizations, including faith-based organizations, are eligible to compete for 3-5 year grants that will range, depending on the number of schools and students served, from $50,000 (mandatory minimum) per year to $200,000 or more. The anticipated levels of funding for Vermont are:

2003 $1.5 million
2004 $2.8 million
2005 $4.7 million
2006 $4.7 million

Who is to be served?
Title IV-B specifies three "absolute" priorities, which include (1) students who attend Title I school-wide program schools, (2) schools that serve a high percentage of students from low-income families (lunch assistance at the school is 40% or greater), and (3) families of students who participate in 21st CCLC programs. In addition, priority points are awarded to schools that have been identified under the state's accountability system as needing technical assistance.

Who are eligible providers?
Schools, institutions of higher education, community-based organizations, including faith-based organizations, and other public or private entities or a consortium of entities are eligible to apply for 21st CCLC grants; however, only those eligible entities willing to work in close partnership with schools are encouraged to apply for CLC funds.

How may CLC funds be used?
Local grantees are limited to providing activities within the following list:

- Remedial education and academic enrichment learning programs, including providing additional assistance to students to allow them to improve their academic achievement;
- Reading, mathematics and science education activities;
- Arts and music education activities;
- Entrepreneurial education programs;
- Tutoring services (including those provided by senior citizen volunteers) and mentoring programs;
- Programs that provide after-school activities for limited English proficient students that emphasize language skills and academic achievement;
- Recreational activities;

- Telecommunications and technology education programs;
- Expanded library service hours;
- Programs that promote parental involvement and family literacy;
- Programs that provide assistance to students who have been truant, suspended, or expelled, to allow the students to improve their academic achievement; and
- Drug and violence prevention programs, counseling programs, and character education programs.

Implementation Plan

Eligible applicants must submit a proposal that includes no more than 15 pages of narrative and 15 pages of supporting documents, including a five-year budget and budget narrative. Altogether, twenty items must be addressed (e.g., goals, inventory of needs, transportation), under five major headings:

- Program need and description (40 Points)
- Capacity for success (15 Points)
- Program management (15 Points)
- Program evaluation (15 Points)
- Budget and budget narrative (15 Points)

A minimum of three independent readers and a panel of experienced CLC leaders evaluate applications using published criteria.

Treatment and Rehabilitation:

Outpatient Treatment Clinicians

- **Why are these services so important?**

Alcohol and drug outpatient, aftercare and recovery services function in much the same way as the way most people receive medical care from a primary care physician in their community. Primary care physicians provide care for most illnesses, refer when necessary, and provide follow-up, aftercare and recovery maintenance.

- **They are accessible and convenient.**
  - Outpatient services (in contrast to residential services) are usually available close to the patient's home and are the most accessible.
  - Outpatient services are the entrance to the system of care. This area must be available because it functions as a front line intervention that helps people stop abusing substances and prevents abuse from getting worse. It also provides the follow-up treatment, aftercare and recovery services for those returning from residential treatment.

- **They are effective and save money. Outpatient services:**
  - serve the most people for the least money.
  - can be used to intervene early to prevent more severe problems.
  - keep people out of more costly residential care.

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Aftercare and Recovery

Research demonstrates that aftercare and recovery maintenance activities help maintain abstinence and other positive outcomes for adolescents and adults.

- Minnesota found that regular and sustained participation in recovery maintenance activities was associated with higher rates of abstinence for adults and youth[1]. .

- A recent publication by the Physician Leadership on National Drug Policy*, focusing on adolescents makes the recommendation to…

> "Increase support of treatment modalities that include a strong focus on recovery management and relapse prevention."

[1] Aftercare program was defined "usually at least weekly sessions with treatment program staff". Peer support group refers to groups such as Alcoholics Anonymous.

*Harrison, P. A., Asche, S. E. (2000, October). The challenges and benefits of chemical dependency treatment: Results from Minnesota's treatment outcomes monitoring system 1993-1999. St. Paul, MN: Minnesota Department of Human Services, Performance Measurement & Quality Improvement, Health Care Research and Evaluation Division.

Where do referrals for treatment come from?
Patients can be referred to outpatient programs from a variety of sources, e.g. self-referrals, physicians, other treatment providers, Departments of Corrections, Social and Rehabilitation, Mental health agencies, other state agencies, courts, etc.

Clinicians and Case Managers:
Up to 100 clients can be served by a clinician in a year. This number can be increased as clinicians practice group therapy where appropriate. Case managers can be expected to about 120 clients per year.

Implementation Plan
1. Funding for an additional 5 clinicians and 5 case managers will be awarded to high need areas.

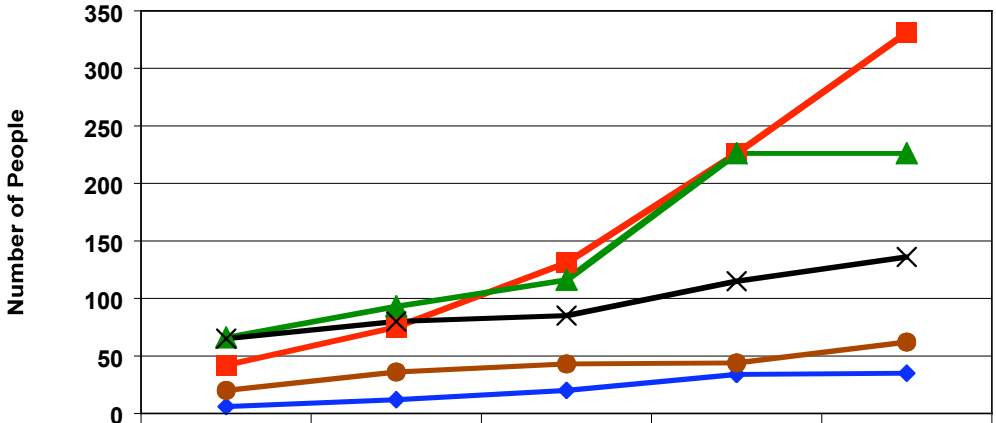
2. Outpatient treatment providers will be asked for information on the need in their area for these services and the capacity they could build upon to ensure that these services will be provided. Particular focus will be paid to underserved areas, evidenced by high utilization, waiting lists, length of wait time, low per capita service rates, and/or areas that will be expected to respond to increasing demands, e.g. drug courts, high number of clients returning from residential treatment. .

3. In July, 2003, providers will be sent letters of request for information.

4. ByAugust, 2003, ADAP will review data on demand and needs in each area and make decisions on the areas with the most serious and immediate needs for outpatient clinicians and case managers. Existing grants with selected providers will be modified to reflect the increased capacity. Providers will be expected to report on services utilization for these new resources

Opiate Treatment Center

Number of Vermonters in Treatment for Heroin



	1998	1999	2000	2001	2002
<18	6	12	20	34	35
18-24	42	75	131	226	331
25-34	66	93	116	226	226
35-44	65	80	85	115	136
45+	20	36	43	44	62

Fiscal Year

Note: Chart does not include Vermonters receiving methadone treatment and/or out of state treatment services.

Current conservative estimates indicate Vermont has more than 1,500 opioid addicted (heroin and other synthetic opioids such as Oxycontin) residents. This is based on the following. During FY2002, 790 Vermonters sought traditional (non-pharmacological) treatment with ADAP funded providers, almost 3 times the number of clients seen in 1999. (See chart.) Moreover, the fastest growing group of users seeking treatment is those aged 18-24. Clearly this is a dangerous indication of a serious problem. Approximately 740 people sought treatment in Conifer, out of state methadone clinics, treatment via the UVM high risk pregnancy clinic, methadone detox at Brattleboro Retreat, or the UVM buprenorphine clinic. 70 of these were Vermonters traveling daily to receive methadone treatment out of state. This represents a total of 1530 seeking some kind of care in FY02 alone. We assume that a significant portion of these would be candidates for long term pharmacological treatment in Vermont. Moreover, these estimates are undoubtedly conservative based on well-known discrepancies between the number of people in need of treatment vs. those requesting treatment, at any given time.

The Burlington clinic, capped at one hundred patients, is currently the only instate option for methadone maintenance treatment. It has an 8-week waiting list (as of 12/6/02), and more patients have applied than it will have room to treat. The 1500 number does not include people currently incarcerated. According to the Department of Corrections, there are at least 80 women that could be transferred to residential and then outpatient treatment for opiate addiction.

Implementation Plan

1. The Department of Health, in collaboration with the Department of Prevention, Assistance, Transition and Health Access (PATH) looked at current expenditures and the number of clients receiving a variety of services. We determined that the current expenditures for treatment and transportation, and number of people being served was sufficient to warrant the opening of another opiate treatment center. Moreover, this center is expected to provide more geographically accessible and/or effective treatment to clients and to reduce the number of Vermonters having to travel out of state..

2. This will be done through release of a new RFP for a program similar to the one currently in operation by Fletcher Allen Health Care. This new program will be required to have a hospital affiliation and to be compliant will all state and federal requirements. We will give preference to proposals for locations in areas not served by the current program. Proposals should be able to demonstrate a need in their catchment area and/or provide more convenient access to currently patients travelling long distances for this treatment. We expect that this new program will have the capacity to treat 100-200 patients.

3. We expect that the RFP can be released in July, 2003 and that the grant will be awarded by September 30, 2003. The grantee will then need 6-8 weeks to seek federal approvals. We expect that a program should be up and running by January 1, 2004.

4. We expect that buprenorphine will also be used for opiate treatment in the next year, and will help provide additional opiate treatment services to some portions of the opiate using population. This will be delivered through approved physician practices.

Offender Re-entry Program

As the Department of Correction's (DOC) treatment role in a case recedes, it is critical that long-term supportive structures and people assume an increasingly prominent place in the offenders' lives. We believe that the recovery model of addictions treatment offers a very appealing option at this point. This would feature peer support, counseling, housing, transportation, and a range of services provided by people and groups who are committed to strengthening their own recovery through assistance to others. We are presently planning this extension of our existing service system through participating community agencies, which will be largely managed by these external groups, such as community action, community mental health centers and other "street level" human service groups. We envision a target group of men and women who have completed the intensive phase of treatment, but who continue to need supportive services and intervention. We believe that these services will best be managed through the community justice centers with support funding through the Re-entry Grant. This sets the stage for relationships that will promote long-term recovery and pro-social functioning. It enables sustainable and meaningful involvement by entities that will be supportive of straight/sober lifestyles after DOC structures are no longer available to the offender.

Implementation Plan

1. Preliminary discussions have been held with the Department of Developmental and Mental Health Services and three community-based mental health groups to identify organizations around the state which might be supportive of this effort. It appears there are a number of individuals who do this type of work, but few organizational entities ready immediately or on short notice to provide the services described. Most existing community recovery groups are unaccustomed to working systemically with corrections clients.

2. We anticipate a three month period of meeting with potential stakeholders, exchanging ideas, developing resources and discussing options for services responsive to the specific needs of corrections clients.

3. The prospective providers will be trained in the unique aspects of working with this population, including the necessity of communication with probation officers and casework staff, confidentiality limitations, drug testing requirements, field site visits by DOC staff and procedures associated with furlough violations and revocations.

4. Funding mechanisms must be determined, consistent with the requirements of the Offender Re-entry Grant. There are two likely options:
   a. Granting of funds directly to the community providers/groups or through a third party such as ADAP or DDMHS, or
   b. An RFP process where different organizational entities submit competitive proposals in response to a corrections-issued RFP. This would be followed by decision by the department to award a contract to one or more of the proposers. This option may not be particularly feasible, given the small size of these organizations, the relatively small amount of money involved, and organizational effort/expertise required to respond to a formal RFP.